MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6481

CERTIFICATE OF DEATH

0639

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 109 Maple Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: T. — Last: Buckalew

4. DATE OF DEATH: Month: June — Day: 8th, — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 15th, 1949

9. AGE (In years last birthday): 10 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: Elementary school

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James E. Buckalew

14. MOTHER'S MAIDEN NAME: Mary Jane Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Address: Frostburg, Md.
Jas. E. Buckalew, 109 Maple St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetic Coma - 260x
DUE TO (b): Diabetes Mellitis uncontrolled
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 24 hrs - DAYS -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from JAN. 1959 to JUNE 8 1960 that (I) (we) last saw the deceased alive on 8 JUNE 1960, and that death occurred at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/10/60

22c. PHYSICIAN'S NAME (Type): John B. Davis, M. D.

22d. ADDRESS: 5 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-11-1960

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery

23d. LOCATION (City, town, or county) (State): Garrett County

24. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst
ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: JUN 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6432

CERTIFICATE OF DEATH

06395

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR MEMORIAL HOSPITAL: MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MORGAN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PAW PAW
d. STREET ADDRESS: BOX 261
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES — Middle RICHARD — Last BULLETT

4. DATE OF DEATH: Month JUNE — Day 4 — Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 16, 1960
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days 19
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): PAW PAW, W.VA.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JACK BULLETT
14. MOTHER'S MAIDEN NAME: SIGLINDE ULLRICH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MEMORIAL HOSPITAL — CUMBERLAND, MARYLAND — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Kernicterus — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO (b): Atresia of Common Bile Duct — Birth

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

756.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 19 60, to June 19 60, that (I) (we) last saw the deceased alive on June 4 19 60 and that death occurred at 8:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: H. Overton Himmelwright M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/6/60
22c. PHYSICIAN'S NAME (Type): DR. OVERTON HIMMELWRIGHT
22d. ADDRESS: 133 VIRGINIA AVE. - CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/5/60
23c. NAME OF CEMETERY OR CREMATORY: Camp Hill
23d. LOCATION (City, town, or county) (State): Paw Paw, Morgan W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C. E. Johnson Berkeley Springs
25a. REC'D BY REGISTRAR DATE: JUN 15 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6433

CERTIFICATE OF DEATH

06396

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 8 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 518 MARYLAND AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CLOVUS	RUSSELL	COX	JUNE	9	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE		AUGUST 24, 1889	70 89 xx yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	SALESMAN	OHIO, Williamsport	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN COX	DORA BELL CAMPBELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	16. SOCIAL SECURITY NO.	17. INFORMANT
no	215-20-5622	WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b) Coronary Arteriosclerosis / Coronary Heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Embolus left femoral artery

410.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from [illegible] 19[illegible] to 6/9, 1960 that (I) (we) last saw the deceased alive on 6/9 1960 and that death occurred at 2:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
George M Simons M.D.		6/10/60

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. GEORGE SIMONS	Algonquin Hotel, Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	6/11/60	Hillcrest Burial Park	Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Cumberland, Maryland	JUN 13 '60	Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6434

CERTIFICATE OF DEATH

06397

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ~~ALLEGANY~~ GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRANTSVILLE, MARYLAND
d. STREET ADDRESS: 11 X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEE; Middle; Last CUSTER

4. DATE OF DEATH: Month JUNE; Day 28; Year 1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
MALE	WHITE		SEPTEMBER 2-1898	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CRANE OPERATOR	DIAMINO CRYSTAL SALTS	GARRETT CO., MD.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN CUSTER	MARY BEACHY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES WW-I + II	274-03-9906	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Arteriosclerotic Cardiovascular disease with
DUE TO (c): Chronic nephritis — and Glaucoma bilateral 6 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Appendectomy - acute perforated June 18, 1960 — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
a. m. / p. m. 19			

21. I **certify** that (I) (this hospital) attended the deceased from June 18, 1960 to June 28, 1960 that (I) (we) last saw the deceased alive on June 28, 1960 and that death occurred at 8:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. X / MED. DIRECTOR ☐ / STAFF PHYS. ☐ M.D.	22b. DATE SIGNED
W.M. Kaw Jr		June 30, 1960

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. W.M. KAW	122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	7/1/60	CASSELMAN MENNONITE	GRANTSVILLE GARRETT CO MD

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Don J. Newman, Grantsville, Md.	JUL 11 '60	Arthur S. Kimes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64-5x

06398
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, nr. Cumberland
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 1 Valley Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural nr, Cumberland
d. STREET ADDRESS: Routel, Valley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUIS — Middle EARL — Last DANIELS

4. DATE OF DEATH: Month June — Day 3 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 6, 1900

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Kelly-Springfield Tire Co.

11. BIRTHPLACE (State or foreign country): Nr. Chaneysville, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Daniels

14. MOTHER'S MAIDEN NAME: Deleva Hartsock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): 1919-1923

16. SOCIAL SECURITY NO.: 309-26-7477

17. INFORMANT: Mrs. Virginia H. Daniels — Address: Rt. 1, Valley Rd. Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carbon Monoxide Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: 1 Hr.
DUE TO (b): Auto exhaust — 1 Hr.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 973.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self induced--ran car in closed garage.

20c. TIME OF INJURY: Hour 3:00 p. m. — Month, Day, Year: June 3 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home garage

20f. (City or town) (County) (State): Rural Rt. Cumberland, All. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: June 4, 1960

EXAMINER'S NAME (Type): Benedict Skitarelic M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 6, 1960

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: JUN 7 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Hinds

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6435

CERTIFICATE OF DEATH

0639?

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 105 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ELLERSLIE
d. STREET ADDRESS: Md. State Rt. # 35
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARVEY Middle ELMER Last DEVORE
4. DATE OF DEATH: Month JUNE Day 4 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 14, 1893
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Mach. Helper
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Bedford C., Penna.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: THOMAS J. DEVORE
14. MOTHER'S MAIDEN NAME: Rachael CLITES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -------
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronal Vascular Accident
DUE TO (b): Hypertension Arteriosclerotic Cardiac Vascular Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 105 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 19 60, to June 19 60, that (I) (we) last saw the deceased alive on June 4 19 60 and that death occurred 7:30 AM from the causes and on the date stated above

22a. SIGNATURE: [signature] M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6/6/60
22c. PHYSICIAN'S NAME (Type): Dr G. Overton Himmelwright
22d. ADDRESS: 133 Virginia Ave, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 7, 1960
23c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery
23d. LOCATION (City, town, or county) (State): Fords Mill, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: H. Jay e George
ADDRESS: 202 Greene St. Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6436

CERTIFICATE OF DEATH

064[illegible]0

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 7/I/59
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Douglas Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hattie; Middle: Mae; Last: Dilfer

4. DATE OF DEATH: Month: 6/I3/60; Day; Year: 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/30/I877

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Miller

14. MOTHER'S MAIDEN NAME: Martha Raley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: P.O. Box 599, Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Chronic Myocardial Dequeneration — INTERVAL BETWEEN ONSET AND DEATH: 36 Hrs

DUE TO (b): Cerebral Arteriosclerosis. — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Chronic Nephritis — ?

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Deterioration & psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/I/59 19___ to 6/II/60 19___, that (I) (we) last saw the deceased alive on 6/ II/60 19___, and that death occurred at 12:25 from the causes and on the date stated above

22a. SIGNATURE: James E. McLean M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6-13-60

22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/15/1960

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d. LOCATION (City, town, or county) (State): Lonaconing, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN
ADDRESS: LONACONING, MD.

25a. REC'D BY REGISTRAR DATE: JUN 16 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6489 Item 7 Filmed 7-14-60 et 06401

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MAIN STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MT. SAVAGE
d. STREET ADDRESS: MAIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PATRICK — Middle ALPHONSUS — Last FANNON
4. DATE OF DEATH: Month JUNE — Day 20, — Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 17, 1879
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): RETIRED SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: QUEEN CITY CANDY CO.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD FANNON
14. MOTHER'S MAIDEN NAME: ELLEN CUNNINGHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-26-9644
17. INFORMANT — Address: MRS. CATHERINE FANNON, MT. SAVAGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) coronary sclerosis — 20 years
DUE TO
(c) age

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)
———

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ———

20c. TIME OF INJURY: Hour — o m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ~~xxxxxxxxxxxxxxxxxxxx~~ at 6-20 19 60 that (I) (we) last saw the deceased alive on 6-20 1960, and that death occurred at 1 P M, from the causes and on the date stated above

22a. SIGNATURE: Otto Vogel M D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-21-1960
22c. PHYSICIAN'S NAME (Type): Otto Vogel, M.D.
22d. ADDRESS: Main Str., Mt Save, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6-23-60
23c. NAME OF CEMETERY OR CREMATORY: ST. PATRICK'S CEMETERY
23d. LOCATION (City, town, or county) (State): MT. SAVAGE, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Durst
ADDRESS: FROSTBURG, MD.
25a. REC'D BY REGISTRAR — DATE: JUN 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6437

CERTIFICATE OF DEATH

06402

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 36 NEW HAMPSHIRE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: L — Last: FEIGHT

4. DATE OF DEATH: Month: 6 — Day: 17 — Year: 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/1/72

9. AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (State or foreign country): MARYLAND Westernport

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GILBERT KIGHT

14. MOTHER'S MAIDEN NAME: SUSAN ADAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: none

17. INFORMANT: CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 201X — Hodgkin's disease
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY: Hour — o. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-13, 1960, to 6-17, 1960 that (I) (we) last saw the deceased alive on 6-17, 1960, and that death occurred at 8:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Earl E. Paul M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. EARL PAUL

22d. ADDRESS: 30 GREENE STREET

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-20-1960
23c. NAME OF CEMETERY OR CREMATORY: Philos Cemetery
23d. LOCATION (City, town, or county) (State): Westernport, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: JUN 21 '60

25b. REGISTRAR'S SIGNATURE: Carlton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66403

1. PLACE OF DEATH — a. COUNTY: Allegany — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Big Savage Mountain — c. LENGTH OF STAY IN 1b: MARYLAND — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3 Miles west of Frostburg, Maryland

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegany — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Big Savage Mountain — d. STREET ADDRESS: 3 Miles west of Frostburg, Maryland — e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: W — Last: GARLICK

4. DATE OF DEATH: Month: June — Day: 20 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Nov 9,1905

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Garlick

14. MOTHER'S MAIDEN NAME: Margaret Cease

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-10-1299

17. INFORMANT: Mrs. Margaret Garlick — Address: Barrellsville, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion, left — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary Sclerosis — ---

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X]. Inspection [X]. Inquiry [X]. and in my opinion death resulted from: Natural causes [X]. Accident [ ]. Suicide [ ]. Homicide [ ]. Undetermined manner [ ]

ACTUAL SIGNATURE: James H Fenster Jr M.D.

EXAMINER'S NAME (Type): James H. Fenster Jr

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [✓]

Address (Street, city, town, or county)

DATE SIGNED: 6-21-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/23/60

22c. NAME OF CEMETERY OR CREMATORY: Cooks Cemetery

22d. LOCATION (City, town, or country) (State): Wellersburg, Maryland

23. FUNERAL DIRECTOR: Ruth E. Silcox — ADDRESS: Cumberland Maryland

24a. REC'D BY REG STRAR — DATE: JUN 27 '60

24b. REGISTRAR'S SIGNATURE: Clifton S Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6482 CERTIFICATE OF DEATH

06403

1 PLACE OF DEATH
a. COUNTY: Allegany

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg

c. LENGTH OF STAY IN 1b: 50 Yrs.

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 38 Frost Avenue

d. STREET ADDRESS: 38 Frost Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Anne Middle C. Last Garrett

4. DATE OF DEATH: Month June Day 16th, Year 19 60

5. SEX: Female

6. COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 12th, 1884

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Housework

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levi T. DeWitt

14. MOTHER'S MAIDEN NAME: Rosamond Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT Address: The Dingle,
Mrs. Marion Sloan, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): [illegible]

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ - OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from [illegible] 19[illegible] to [illegible] 19[illegible] that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: [illegible] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: [illegible]

22c PHYSICIAN'S NAME (Type): Martin M. Rothstein, II

22d. ADDRESS: 48 Broadway, Frostburg, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6-20-60

23c NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

23d LOCATION (City, town, or county) (State): Frostburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: [illegible]

ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE JUN 20 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6439 **CERTIFICATE OF DEATH** Reg. Dist. No. 06405

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 505 Greene Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle L. — Last GATES
4. DATE OF DEATH: Month June — Day 30 — Year 19 60
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 6, 1879
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian
10b. KIND OF BUSINESS OR INDUSTRY: Bank
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edward Gates
14. MOTHER'S MAIDEN NAME: Maude Scott
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217 14 4029
17. INFORMANT: Robert Gates — Address: Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): NEPHROSCLEROSIS - HYPERTENSION — 6 months
DUE TO
(c): Cerebral PROSTATIC OBSTRUCTION — 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Heart failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL-EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 1, 19 [illegible] to June 30, 19 60 that I last saw the deceased alive on June 25, 19 60, and that death occurred at 12:15 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 54 GREENE — DATE SIGNED: 7/1/60
PHYSICIAN'S NAME (Type): [illegible] Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 2, 1960
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: JUL 5 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6439 — Reg. Dist. No. 05406

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 328 Davidson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLOUGHBY — Middle H. — Last GAYHART

4. DATE OF DEATH: Month June — Day 26 — Year 19 60

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: March 10,1895 — 9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael Gayhart
14. MOTHER'S MAIDEN NAME: Martha Harrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 139 09 20638
17. INFORMANT: Mrs. Clara Gayhart — Address: Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SUBDURAL HEMORRHAGE, MASSIVE — INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs.

DUE TO (b): SKULL FRACTURE — 12 Hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 903.5

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell on Street, 19 E. Laing Ave. Cumberland, Md.
20c. TIME OF INJURY: Hour 6:00 a.m. p.m. Month, Day, Year: June 25 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) (County) (State): Cumberland, Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: June 26, 1960

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 29,1960
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: JUN 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6491 06467

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 2 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 307 Rock

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 307 Rock
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Lulu Middle: Jane Last: Grove

4. DATE OF DEATH: Month: June Day: 9 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 5, 1887
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Grove
14. MOTHER'S MAIDEN NAME: Harriett L Fazenbaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: James Grove-Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 10 Days
DUE TO (b): Arteriosclerotic heart disease — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Endometrium
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour: a. m. p. m. Month: Day: Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1959 to June 9, 1960, that (I) (we) last saw the deceased alive on June 7, 1960, and that death occurred at 4:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William W. Lesh M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): William W. Lesh, M.D.
22d. ADDRESS: 24 Main St. Westernport, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/10/60
23c. NAME OF CEMETERY OR CREMATORY: Philos
23d. LOCATION (City, town, or county) (State): Westernport Md

24. FUNERAL DIRECTOR'S SIGNATURE:
ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE: JUN 9 '60
25b. REGISTRAR'S SIGNATURE: Clifton L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6440 — 03408 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 13 Laing Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS — Middle E — Last HAINES
4. DATE OF DEATH: Month JUNE — Day 8 — Year 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 9, 1886
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Higginsville, W.Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James H. Haines
14. MOTHER'S MAIDEN NAME: Margaret Foltz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CHRONIC MYOCARDITIS; PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 8 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CORONARY ARTERY DISEASE — ----
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): FRACTURE OF FIFTH RIB, RIGHT
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): FELL AT HOME
20c. TIME OF INJURY Month, Day, Year: Hour 11:30 a.m. JUNE 2 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): CUMBERLAND, ALLEG. MD.

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: JUNE 8, 1960
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-10-60
22c. NAME OF CEMETERY OR CREMATORY: Allegany Co. Cemetary
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli Cumberland, Md
24a. REC'D BY REGISTRAR DATE: JUN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06409

6496

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, nr, Cumberland
c. LENGTH OF STAY IN 1b: years
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Route 2, Williams Road

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, nr, Cumberland
d STREET ADDRESS: Route 2, Williams Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FREDA — Middle: ELIZABETH — Last: HARTLEY

4. DATE OF DEATH: Month: June — Day: 9 — Year: 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 18, 1910
9 AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Swift & Co.
11. BIRTHPLACE (State or foreign country): Bedford County, Pennsylvania
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Roberts
14. MOTHER'S MAIDEN NAME: Eliza Bowden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: 220-10-4867
INFORMANT: Claude Hartley — Address: Route 2, Williams Road Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Neoplasm left Adenocarcinoma generalized Metastases — INTERVAL BETWEEN ONSET AND DEATH: 4 Months
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 59, to 6-8-, 19 60 that I last saw the deceased alive on 6-5-, 19 60, and that death occurred at 1:45 M, from the causes and on the date stated above

ACTUAL SIGNATURE: J. T. Johnson M.D — ADDRESS (Street, city or town, state): 16 Greene St Cumberland Md — DATE SIGNED: 6-10-60

PHYSICIAN'S NAME (Type): James T. Johnson M.D. 16 Greene Street, Cumberland, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 11, 1960
22c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery
22d LOCATION (City, town, or county) (State): Allegany County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE: JUN 13 '60
24b REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6441 — Reg. Dist. No. 0410

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: West Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle — Last Hutchenson

4. DATE OF DEATH: Month June — Day 4 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 14,1876
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Marshall
14. MOTHER'S MAIDEN NAME: Margaret McKinley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Arch Hutchenson — Address: Cumberland, Md. "Son"

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SUBDURAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 3 Wks.

DUE TO (b): CONTUSIONS OF BRAIN — "

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

900.6

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PNEUMONIA , BILATERAL

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): FELL DOWN THREE STEPS
20c. TIME OF INJURY: Hour — Month, Day, Year: a. m. 3/40 p m — 4/18/60
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): G. C. Murphy Co.
20f. (City or town) (County) (State): CUMBERLAND, ALLEG. MD.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: JUNE 4, 1960
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/7/60
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn — ADDRESS: Lonaconing, Md.
24a. REC'D BY REGISTRAR: DATE JUN 8 '60
24b. REGISTRAR'S SIGNATURE: Arthur S Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6442 **CERTIFICATE OF DEATH** 0841

Item 8 Film G264 6/15/60 lwk

1 PLACE OF DEATH
a COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c LENGTH OF STAY IN 1b: 15 DAYS
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.

2. USUAL RESIDENCE (Where deceased lived — If institution Residence before admission)
a STATE: MARYLAND
b COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d STREET ADDRESS: 216 SOUTH STREET, CUMBERLAND, MD.
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BERTHA Middle A. Last HYMES

4. DATE OF DEATH: Month JUNE Day 6 Year 19 60

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 6, 1887 (1886)
9 AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Ownhome
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AUGUST HOUSER
14. MOTHER'S MAIDEN NAME: CATHERINE TROLL

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: None
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cardiovascular disease DUE TO (c) Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: Years / Days 4 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 1-4- 19 44 to 6-6- 19 60 that (I) ~~(we)~~ lost saw the deceased alive on 6-6- 19 60 and that death occurred at 3:55 P.M. the causes and on the date stated above.

22a SIGNATURE: M. G. Williams M.D.
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED
22c PHYSICIAN'S NAME (Type): DR.W.F. WILLIAMS
22d ADDRESS: 122 SOUTH CENTRE ST., CUMBERLAND, MD.

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6-9-60
23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli Cumberland, Md.
25a REC'D BY REGISTRAR DATE JUN 13 '60
25b REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6497

CERTIFICATE OF DEATH

06412

1. PLACE OF DEATH
a. COUNTY: Allegheny — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Md, R, D.5
c. LENGTH OF STAY IN 1b: 25 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W Va
b. COUNTY: Preston
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kingwood W Va
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Anna — Middle Brailer — Last Jefferys

4. DATE OF DEATH: June 23 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 24 1877

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Keyser Ridge, M D

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ambrose Brailer

14. MOTHER'S MAIDEN NAME: Elizabeth Knecht

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Adeline Dunkinburger Cumberland Md R5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Yr.
170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cancer of Left Breast — 5 Yr.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension + Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible] 19[illegible] to June 23, 1960, that (I) (we) last saw the deceased alive on June 23 1960, and that death occurred at 5:30 A.M. from the causes and on the date stated above

22a. SIGNATURE: [signature] M.D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6-27-60

22c. PHYSICIAN'S NAME (Type): S. G. WEISMAN M.D.

22d. ADDRESS: 54 Glen [illegible] Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6- 27-60

23c. NAME OF CEMETERY OR CREMATORY: St Joseph

23d. LOCATION (City, town, or county) (State): Howesville W Va

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: H. L. Brown, Kingwood, W Va,

25a. REC'D BY REGISTRAR DATE: 6/25/60

25b. REGISTRAR'S SIGNATURE: Lucy C Shaffer

JUN 27 '60

Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6443 **CERTIFICATE OF DEATH** 06413

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b 12 years
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 241 New Hampshire Ave.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d STREET ADDRESS 107 Luteman Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CRATES Middle S. Last JOHNSON
4. DATE OF DEATH Month June Day 17 Year 1960
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH March 4,1873
9 AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister
10b. KIND OF BUSINESS OR INDUSTRY Ministry
11. BIRTHPLACE (State or foreign country) Indiana
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Cyrus Johnson
14 MOTHER'S MAIDEN NAME Elizabeth Ballard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO None
17. INFORMANT Address Mrs. N. O. Scribner, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO (b) Generalized arteriosclerosis
DUE TO (c) Uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 42 21

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October, 1953, to June 17, 1960, that I last saw the deceased alive on June 15, 1960, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE George M. Brown M.D. ADDRESS (Street, city or town, state) Allegany Hotel DATE SIGNED 6/17/60
PHYSICIAN'S NAME (Type) Cumberland, Md.

22a BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF June 21,1960
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln
22d. LOCATION (City, town, or county) (State) Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight ADDRESS Cumberland, Md.
24a. REC'D BY REGISTRAR DATE JUN 21 '60
24b. REGISTRAR'S SIGNATURE C. Thos S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6444

CERTIFICATE OF DEATH

06414

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL, MEMORIAL AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY
d. STREET ADDRESS: RT. #1,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARRIE — Middle V. — Last KENNEY

4. DATE OF DEATH: Month JUNE — Day 14 — Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: FEBRUARY 27, 1908
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Ridgeley, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HANSON SENN
14. MOTHER'S MAIDEN NAME: SOPHIE ABE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage with at Employee
DUE TO (b): Hypertension and Arteriosclerosis
DUE TO (c): Coronary Disease
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour — a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 9 19 60 to June 14 19 60 that (I) (we) last saw the deceased alive on June 13 19 60 and that death occurred at 3:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm Alfred Van Ormer M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): DR. W.A. VAN ORMER, 122 S. CENTRE ST.
22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 17, 1960
23c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery
23d. LOCATION (City, town, or county) (State): Fort Ashby, W.Va.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR — DATE: JUN 20 '60
25b. REGISTRAR'S SIGNATURE: Clarence S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6492 **CERTIFICATE OF DEATH** 06415

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 **PLACE OF DEATH** a. COUNTY: Allegany — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport

c. LENGTH OF STAY IN 1b: 33 yr.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 106 Greene St.

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Westernport

d STREET ADDRESS: 106 Greene St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Matilda Middle: Last: Lambert

4. **DATE OF DEATH**: Month: June Day: 21, Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 17, 1883

9. AGE (In years last birthday): 76 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Franklin, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Halterman

14. MOTHER'S MAIDEN NAME: Arbelin Simmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16 SOCIAL SECURITY NO.:

17 **INFORMANT** Address: Oscar Lambert, 106 Greene St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 486X Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Influenza — 10 Days

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Nephritis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): None

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from June 13 1960 to June 21 1960, that (I) (~~was~~) last saw the deceased alive on June 21 1960, and that death occurred at 8:? M. from the causes and on the date stated above

22a SIGNATURE: Paul R Wilson M D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: June 22, 1960

22c PHYSICIAN'S NAME (Type): Paul R. Wilson, M.D

22d ADDRESS: 111 Ashfield St. Piedmont, W. Va.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: June 24, '60

23c NAME OF CEMETERY OR CREMATORY: Philos Cemetery

23d LOCATION (City, town, or county) (State): Westernport, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: E J Beal ADDRESS: Westernport, Md.

25a REC'D BY REGISTRAR DATE: JUN 27 '60

25b REGISTRAR'S SIGNATURE: Arthur S Kuhns

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6445

CERTIFICATE OF DEATH

0641

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 311 Franklin Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d STREET ADDRESS: 311 Franklin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ASA Middle WILLIAM Last LEWIS

4. DATE OF DEATH: Month June Day 27 Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 11, 1880

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Brewery Wkr

10b. KIND OF BUSINESS OR INDUSTRY: Cumberland Brewery

11. BIRTHPLACE (State or foreign country): Near Kifer, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Asa Lewis

14. MOTHER'S MAIDEN NAME: Elizabeth Moreland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Rosa Lewis — Address: 311 Franklin Street Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteri-Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Arteri sclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 26 June 60, to 26 June 60, that (I) (we) last saw the deceased alive on 26 June 60 and that death occurred on 6/27 AM, from the causes and on the date stated above

22a SIGNATURE: David T Rees M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 6/29/60

22c PHYSICIAN'S NAME (Type): David T. Rees M.D.

22d. ADDRESS: 702 Montgomery Ave, Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/30/60

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 6 '60

25b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 0641?

6446

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: #3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRESAPTOWN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAROLD — Middle — Last LIMBERT

4. DATE OF DEATH: Month June — Day 10 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ~~1/23/02~~ 1/23/02

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ENGLAND, Derby

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE LIMBERT

14. MOTHER'S MAIDEN NAME: ALICE ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: CHART — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis, generalized — INTERVAL BETWEEN ONSET AND DEATH: 6 Months

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of stomach (primary site) — 1 year

DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: JUNE 10, 1960

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/12/60
22c. NAME OF CEMETERY OR CREMATORY: Zionn Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer
ADDRESS: Cumberland, Md
24a. REC'D BY REGISTRAR: DATE JUN 13 '60
24b. REGISTRAR'S SIGNATURE: Cathur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

644?

0641S

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 230 Avirett Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: — Last: Lohof

4. DATE OF DEATH: Month: June — Day: 28, — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 7, 1898

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Parking lot Mgr.

10b. KIND OF BUSINESS OR INDUSTRY: Parking lot

11. BIRTHPLACE (State or foreign country): Amsterdam, Holland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William Lohof

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 151-09-3281

17. INFORMANT: Address: Mrs. Edna Lohof 230 Avirett Ave., Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intra-cranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days

900.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Skull fracture — 10 days

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell down steps at residence

20c. TIME OF INJURY: Hour: 1:30 o. m. — Month, Day, Year: 6/19/1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Cumberland Allegany Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 6/29/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/1/60

22c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

22d. LOCATION (City, town, or county) (State): Hyndman, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: JUL 5 '60

24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6443 — 06419 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X La Vale
d. STREET ADDRESS: 22 McKenzie Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle RUSSELL — Last LONG
4. DATE OF DEATH: Month June — Day 7, — Year 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 2, 1906
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Acetate Dept. worker
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George W. Long
14. MOTHER'S MAIDEN NAME: Virginia Rice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-10-6070
17. INFORMANT: Mrs. Minnie H. Long — Address: La Vale, Md. 22 McKenzie Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Coronary Sclerosis with thrombosis — ----
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
JUNE 7, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/10/60
22c. NAME OF CEMETERY OR CREMATORY: Mount Herman Cem./
22d. LOCATION (City, town, or county) (State): Nr. Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George
ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: JUN 10 '60
24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within [redacted] hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9 Film 3764 6/13/60 iwk

06421

6449

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 480 Baltimore Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 480 Baltimore Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRIETT Middle SUSAN Last MARTIN

4. DATE OF DEATH: Month JUNE Day 7 Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 9, 1893
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant Mgr
11. BIRTHPLACE (State or foreign country): Greenriuge, Alleg. Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Twigg
14. MOTHER'S MAIDEN NAME: Sarah Hudson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 214-30-9885
INFORMANT: Mr. Wm. C. Martin Address: 480 Balt. Avenue Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Arteria Sclerotic Heart Disease — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Diabetis mellitus — 20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour ____ a. m. p. m. Month ____ Day ____ Year 19 ____
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Michael L. Glick M.D. ADDRESS (Street, city or town, state): 126 North Smallwood St. Cumberland, Md DATE SIGNED

PHYSICIAN'S NAME (Type): Michael L. Glick, M.D. 6/9/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/11/60
22c. NAME OF CEMETERY OR CREMATORY: Fairview Christian Cem
22d. LOCATION (City, town, or county) (State): Bedford County, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: JUN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6493 **CERTIFICATE OF DEATH** 06421

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M II/59

1. PLACE OF DEATH — a. COUNTY: Allegany — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Md. — b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] — c. LENGTH OF STAY IN 1b: [illegible] — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 407 Spruce St. — d. STREET ADDRESS: 407 Spruce St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Matthews
4. DATE OF DEATH: Month: June — Day: 29, — Year: 19 60

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 25, 1888 — 9. AGE (In years last birthday): 71 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible] — 10b. KIND OF BUSINESS OR INDUSTRY: [illegible] R.R. — 11. BIRTHPLACE (State or foreign country): Cunningham, Md. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible] Matthews — 14. MOTHER'S MAIDEN NAME: Susan Ann Carey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): [illegible] — (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: 712-14-1656 — 17. INFORMANT: Mrs. Mabel Matthews, — Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 10 Hours
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): None

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 29 1960 to June 29 1960, that (I) (we) last saw the deceased alive on June 29 1960, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Paul R. Wilson M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: June 30, 1960
22c. PHYSICIAN'S NAME (Type): Paul R. Wilson M.D. — 22d. ADDRESS: 111 Ashfield St. Piedmont, W.Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: July 2, 1960 — 23c. NAME OF CEMETERY OR CREMATORY: Philos Cemetery — 23d. LOCATION (City, town, or county) (State): Westernport, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: E. L. Bond — ADDRESS: Westernport, Md. — 25a. REC'D BY REGISTRAR DATE: JUL 5 '60 — 25b. REGISTRAR'S SIGNATURE: Clifford B. Friend

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6495 — 06422 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Motel 8 Mi. East of Cumb. Rt. 40

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 206 Penna. Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Archie — Middle: Albert — Last: McDonald

4. DATE OF DEATH: Month: June — Day: 4, — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 21, 1904

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy.

11. BIRTHPLACE (State or foreign country): Romney, W. Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wesley H. McDonald

14. MOTHER'S MAIDEN NAME: Georgia O'Scannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-03-8310

17. INFORMANT: Mrs. Elsie M. McDonald — Address: Cumb. Md. 206 Penna. Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary sclerosis — ?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/5/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/8/60
22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery
22d. LOCATION (City, town, or county) (State): Nr. Romney, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: H. Wayne George Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: JUN 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6450

CERTIFICATE OF DEATH

05423

1 PLACE OF DEATH
a COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 20minutes
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RT.# 5 Cumberland,
d. STREET ADDRESS: Fairgo
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Gallitzen E. Leo McKenzie
4. DATE OF DEATH: Month 6 Day 9 Year 1960

5 SEX: Male
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: June 4, 1893
9 AGE (In years last birthday): 67
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b KIND OF BUSINESS OR INDUSTRY: Construction
11 BIRTHPLACE (State or foreign country): Cresaptown, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel McKenzie
14. MOTHER'S MAIDEN NAME: Alice Winters

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, (If yes, give war or dates of service) W.W.# 1
16 SOCIAL SECURITY NO: 217-10-7676
17 INFORMANT Address: Mrs. Marie H. McKenzie Rt. # 5 Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 4-22-1959 to 6-9-1960, that (I) (we) last saw the deceased alive on 6-9-1960, and that death occurred at 8 a.m., from the causes and on the date stated above

22a. SIGNATURE: Ezra W Ballin, M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c PHYSICIAN'S NAME (Type): DR. R.W BALLIN
22d ADDRESS: 62 GREENE STREET 6-10-60

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6/11/60
23c NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul's
23d LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Charles L. George Cumberland, Md.
25a REC'D BY REGISTRAR DATE: JUN 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6451

0642

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 57 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FLINTSTONE
d. STREET ADDRESS: ROUTE #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First HARRY Middle ANTHONY Last MC LUCKIE
4. DATE OF DEATH: Month JUNE Day 18 Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: OCTOBER 20, 1889
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: Dairy Farm
11. BIRTHPLACE (State or foreign country): FROSTBURG, MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ANDREW MC LUCKIE
14. MOTHER'S MAIDEN NAME: ALICE LARUE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 214-36-7184
17. INFORMANT: WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Carcinoma of Esophagus — INTERVAL BETWEEN ONSET AND DEATH: Years / Months / Weeks
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-16-1960 to 6-18-1960 that (I) (we) last saw the deceased alive on 6-18-1960 and that death occurred at 10:35 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. F. Williams M.D.
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED: 6-20-60
22c. PHYSICIAN'S NAME (Type): DR. W.F. WILLIAMS
22d. ADDRESS: Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/21/60
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Maryland
25a. REC'D BY REGISTRAR DATE: JUN 24 '60
25b. REGISTRAR'S SIGNATURE: Curtis L. Finan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6452

CERTIFICATE OF DEATH

6425

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
ISM 9/59

PLACE OF DEATH a. COUNTY: Allegany — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 16: 3½ hrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland

d. STREET ADDRESS: 800 Yale St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Clara	S.	Meister	June	11	1960

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
Female	White		8/24-90	69 yrs				

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Retired Clerk	Stationery Store	Maryland	U.S.A.

13. FATHER'S NAME: John Zimmerly

14. MOTHER'S MAIDEN NAME: Annie Dreyer

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16 SOCIAL SECURITY NO: NONE

17 INFORMANT: Charles Meister Address 800 Yale Street Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Arteriosclerotic Cardio-Vascular

DUE TO (c): Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21 **I certify** that (I) (this hospital) attended the deceased from 5/18, 19 60, to 6/11, 19 60, that (I) (we) last saw the deceased alive on 6/11 19 60, and that death occurred at 5:20 P.M., from the causes and on the date stated above

22a. SIGNATURE: Leo Ley Jr. M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b DATE SIGNED: 6/13/60

22c PHYSICIAN'S NAME (Type): Leo Ley, Jr.

22d. ADDRESS: N. Center St. Cumberland, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City town, or county) (State)
Burial	6/14/60	Trinity Lutheran Cemetery	Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
John J. Hafer, Cumberland, Maryland	JUN 16 '60	Cathryn L. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6453

CERTIFICATE OF DEATH

06426

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LA VALE
d. STREET ADDRESS: 1219 VOCKE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Paulet — Middle: Cathy — Last: MIGDOL

4. DATE OF DEATH: Month: JUNE — Day: 7 — Year: 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 5, 1960

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months — Days: 2 — IF UNDER 24 HRS: Hours: 1 — Min.: 24

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL MIGDOL

14. MOTHER'S MAIDEN NAME: CATHREAN FUNK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity 2 1/2 wks. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Premature Separation Placentae
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

761.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a m / p m — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19____, to ____, 19____, that (I) (we) last saw the deceased alive on ____, 19____, and that death occurred at 1:45 AM from the causes and on the date stated above.

22a. SIGNATURE: Fuller B Whitworth M.D

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): F. B. WHITWORTH

22d. ADDRESS: 123 BEDFORD ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 8, 1960

23c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

23d. LOCATION (City, town, or county) (State): Hyndman, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Harry A. Feagley

ADDRESS: Hyndman, Pa.

25a. REC'D BY REGISTRAR DATE: JUN 10 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

2060307XV1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6483 **CERTIFICATE OF DEATH** Reg. Dist. No. 06427

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Frostburg
d. STREET ADDRESS: R.D. #1, Woodland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OLIVER Middle D. Last MORGAN

4. DATE OF DEATH: Month 6 Day 29 Year 1960.

5 SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 6/5/25
9. AGE (In years last birthday): 34 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glass Worker
10b KIND OF BUSINESS OR INDUSTRY: retired(illness)
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David J. Morgan
14. MOTHER'S MAIDEN NAME: Sylvia (Spencer) Morgan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: 220-16-5557
INFORMANT: Address Frostburg, Md. Mrs. Oliver D. Morgan, R.D.#1, Woodland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
DUE TO (b): Congenital Cardiac Defect — 5yr
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1960 to June 29 1960 that I last saw the deceased alive on June 28 1960 and that death occurred at 9:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: W O McLane — ADDRESS (Street, city or town, state): Frostburg Md — DATE SIGNED: June 30 1960
PHYSICIAN'S NAME (Type): W O McLane

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-2-60
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park
22d. LOCATION (City, town, or county) (State): Frostburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Everett H. Montcastle — ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

24a. RECEIVED BY REGISTRAR DATE: JUL 11 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6490

0642

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: New Row

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
d. STREET ADDRESS: New Row
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Joseph — Last: Mulligan

4. DATE OF DEATH: Month: June — Day: 10th — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 21st, 1871

9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Carman

10b. KIND OF BUSINESS OR INDUSTRY: C&P R.R.Shops

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Mulligan

14. MOTHER'S MAIDEN NAME: Bridget Farrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 712-16-6260

17. INFORMANT: Carl Mulligan, Mt.Savage, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart weakness:acute insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): General arteriosclerosis,coronary sclerosis — 10 yea
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Age

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ri left lower lobe pneumonia. Ri-sided hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour — a m / p m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-15 1960 to 6-10 1960, that (I) (we) last saw the deceased alive on 6-10 1960 and that death occurred at 7 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Otto Vogel MD — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 6-11-60

22c. PHYSICIAN'S NAME (Type): Otto Vogel M.D.

22d. ADDRESS: Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-13-60

23c. NAME OF CEMETERY OR CREMATORY: St.Patrick's Cemetery

23d. LOCATION (City, town or county) (State): Mt. Savage, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. L. Lucas Jr. — ADDRESS: Frostburg, Md.

25a. RECEIVED BY REGISTRAR — DATE: JUN 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6454 — 0643 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 441 N. Centre St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Corriganville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CECIL — Middle: H. — Last: MYERS

4. DATE OF DEATH: Month: June — Day: 6 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 23,1914

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery operator

10b. KIND OF BUSINESS OR INDUSTRY: retail grocery

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H. Myers

14. MOTHER'S MAIDEN NAME: Mary E. Rephann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215 16 4440

17. INFORMANT: Mrs. Hazel McCormick — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY SCLEROSIS
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: JUNE 6,1960

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 9,1960
22c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery
22d. LOCATION (City, town, or county) (State): Eckhart, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: JUN 9 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Kinsel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6455 — 0643 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 20 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Westernport
d. STREET ADDRESS: 139 Front
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEE — Middle: — Last: NASSER
4. DATE OF DEATH: Month: JUNE — Day: 6 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 28, 1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Lebanon
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Raphael
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Louis Nasser — Address: Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
904.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): FRACTURE OF RIGHT HIP
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): FELL IN BATHROOM AT HOME
20c. TIME OF INJURY: Hour: 7:00 a. m. — Month, Day, Year: May 19 1960
20d. INJURY OCCURRED: White at work ☐ Not white at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Westernport (County): Alleg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Sktarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: JUNE 6, 1960
EXAMINER'S NAME (Type): BENEDICT SKTARELIC, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/9/60
22c. NAME OF CEMETERY OR CREMATORY: St. Peters
22d. LOCATION (City, town, or county) (State): Westernport, Md

23. FUNERAL DIRECTOR'S SIGNATURE: E.K. Broad — ADDRESS: Westernport, Md.
24a. REC'D BY REGISTRAR DATE: JUN 9 '60
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any details are necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5) 5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6456

CERTIFICATE OF DEATH

06432

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 505 MARYLAND AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ESTHER — Middle: ----- — Last: NORTH
4. DATE OF DEATH: Month: June — Day: 1 — Year: 1960
5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/3/77
9. AGE (In years last birthday): 82 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife,
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Black Valley, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Martin LUTHER WILSON
14. MOTHER'S MAIDEN NAME: EMILY BENNETT
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Mr. Martin Gordon Rt. # 1 Flintstone, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditis with Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO (b): Generalized Arteriosclerosis — 5 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-23 19 60 to 6-1 19 60 that (I) (we) last saw the deceased alive on 5-31 19 60 and that death occurred at 7:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: J. T. Johnson, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 6-2-60
22c. PHYSICIAN'S NAME (Type): DR. J.T. JOHNSON
22d. ADDRESS: 16 GREENE ST

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 6/3/60 — 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park — 23d. LOCATION (City, town, or county) (State): Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 6 '60 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A1E (4) ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6457

CERTIFICATE OF DEATH

06433

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 4/15/58

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

d. STREET ADDRESS: 106 Frederick Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Last: Paul

4. DATE OF DEATH: Month: June Day: 18, Year: 19 60

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/11/1879

9. AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired: Florist

10b. KIND OF BUSINESS OR INDUSTRY: Florist - Proprietor

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John A. Paul

14 MOTHER'S MAIDEN NAME: Margaret Minnick

15 WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT: P. O. Box 599 Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Arterial Arteriosclerosis,

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c): Chronic Nephritis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes of 5 years with Senility

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 4/15/58 19 , to 6/18/60, 19 , that (I) (we) last saw the deceased alive on 6/17/60 19 , and that death occurred at 8:40 PM, from the causes and on the date stated above.

22a. SIGNATURE: James E. McLean M D

ATTENDING PHYS ☒ MED DIRECTOR ☒ STAFF PHYS ☒

22b. DATE SIGNED: 6/20/60

22c PHYS CAN'S NAME (Type): Dr. James E. McLean

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6/21/60

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum

23d. LOCATION (City, town or county) (State): Cumberland Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James Stein Inc. ADDRESS: Cumb. Md.

25a RECD BY REGISTRAR DATE: JUN 22 '60

25b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6458

CERTIFICATE OF DEATH

06436

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 HRS. 15 MIN.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRANTSVILLE,
d. STREET ADDRESS: STAR ROUTE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SHIRLEY — Middle ANN — Last PLATTER

4. DATE OF DEATH: Month JUNE — Day 4 — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 14, 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months 3 — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MEYERSDALE, PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: PEGGY JOYCE PLATTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): SUBENDO CARDIAL Fibroelastosis — INTERVAL BETWEEN ONSET AND DEATH: 3 months

754.4

DUE TO (b): with Cardiac Failure and dilitation heart

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Thrush

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from June 3, 1960 at 9:15 A.M. to June 4, 1960, that (I) (we) last saw the deceased alive on June 4, 1960, and that death occurred at 3:__ M, from the causes and on the date stated above.

22a SIGNATURE: R. A. Reiter, M.D.

M.D | ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. REITER

22d. ADDRESS: 112 Bedford St. Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/5/60

23c NAME OF CEMETERY OR CREMATORY: Bittinger

23d. LOCATION (City, town, or county) (State): BITTINGER GARRETT Co MD

24 FUNERAL DIRECTOR'S SIGNATURE: Don Thurman — ADDRESS: Grantsville, Md.

25a. REC'D BY REGISTRAR — DATE JUN 9 '60

25b. REGISTRAR'S SIGNATURE: Clinton S. Kuhns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6459 **CERTIFICATE OF DEATH** 06435

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 4/25/60

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cumberland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

d. STREET ADDRESS: Rt.I, Homewood Addition

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry Middle: Homer Last: Price

4. DATE OF DEATH: Month: June Day: I2 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: II/26/I902

9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Barber

10b. KIND OF BUSINESS OR INDUSTRY: Barber

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George H. Price

14. MOTHER'S MAIDEN NAME: Grace Binnix

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 220-10-8847

17. INFORMANT: Address: Po. Box 599 Cumberland, Md. Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 5 mos

DUE TO (b): Cerebral arteriosclerosis. — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Spastic paraplegia. — 5 mos

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive Cardio Vascular Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 4/25/60, 19___, to 6/II/60, 19___, that (I) (we) last saw the deceased alive on 6/II/60 19___, and that death occurred I:40 P.M. from the causes and on the date stated above

22a. SIGNATURE: James E. McLean M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☒ STAFF PHYS ☒ — 22b. DATE SIGNED: 6-13-60

22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 15, 1960

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George, ADDRESS: Cumberland, Md.

25a. RECD BY REGISTRAR DATE: JUN 16 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6460

6C456
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 107 Mary St

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 107 Mary Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Carl — Last: Pryor

4. DATE OF DEATH: Month: June — Day: 2 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 20, 1897

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinists Helper

10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob A. Pryor

14. MOTHER'S MAIDEN NAME: Susan Bridenthall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-05-5152

17. INFORMANT: Michael H. Pryor — Address: Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO (b): CORONARY SCLEROSIS — ----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.D

DATE SIGNED: JUNE 2, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 4, 1960

22c. NAME OF CEMETERY OR CREMATORY: Prosperity Methodist Cem.

22d. LOCATION (City, town, or county) (State): Allegany County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc — ADDRESS: 117 Frederick St. Cumb. Md.

24a. REC'D BY REGISTRAR: JUN 6 '60

24b. REGISTRAR'S SIGNATURE: Luther S. Frank

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6484

CERTIFICATE OF DEATH

06457

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY — Middle — Last QUINN

4. DATE OF DEATH: Month 6/29/1960 — Day — Year 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/20/1878

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing, MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Quinn

14. MOTHER'S MAIDEN NAME: Sarah Murry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Miss Julia Quinn, Midland, MD. (SISTER)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Carcinoma transverse colon — INTERVAL BETWEEN ONSET AND DEATH: ?

153.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fractured Left hip - Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1958 to June 22, 1960 that (I) (we) last saw the deceased alive on June 22 1960, and that death occurred at 11 a.m., from the causes and on the date stated above

22a. SIGNATURE: [signature] M.D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): L.R. MILES JR., M.D.

22d. ADDRESS: LONACONING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/2/1960

23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

23d. LOCATION (City, town, or county) (State): Lonaconing, MD.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: George Eichhorn, Lonaconing, MD.

25a. REC'D BY REGISTRAR DATE JUL 6 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6461

CERTIFICATE OF DEATH

06435

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 9/19/56

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

d. STREET ADDRESS: 450 Waverly Terrace

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: John — Middle: L. — Last: Ring

4 DATE OF DEATH: Month: June — Day: 5, — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH: 8/3/1877

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY: For: Cumberland Steele Co.

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: Peter Ring

14. MOTHER'S MAIDEN NAME: Elizabeth Gleichman

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No,

16. SOCIAL SECURITY NO: 214-05-8876

17 INFORMANT: P.O.Box 599 Address: Cumberland, Md.
A Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO (b): Cerebral Arteriosclerosis, — ?

DUE TO (c): Chronic Syphilis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5 9 = X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Deterioration

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour, a. m. p. m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 9/19/56 19 to 6/5/60 19, that (I) (we) last saw the deceased alive on 6/4/60 19, and that death occurred at 11:55 A.M., from the causes and on the date stated above

22a SIGNATURE: James E. McLean M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☒ STAFF PHYS ☒

22b. DATE SIGNED: 6-6-60

22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean

22d ADDRESS: 49 Greene St., Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 6/9/60

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Maryland

25a REC'D BY REGISTRAR DATE: JUN 10 '60

25b REGISTRAR'S SIGNATURE: Arthur S. Hawse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06439

Reg. Dist. No. 6462

PLACE OF DEATH a. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cumberland, (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Memorial Hosp.

d. STREET ADDRESS: R. D. # 3.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
RUSSELL	LUE	ROBINETTE	June	24,	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		4/3/1910	50 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Welder	Welding Co.	R.D. # 3 Cumberland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Olver Robinette	Alice Irons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-07-6700	Mrs. Blanche Robinette Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Blast Injury — Sudden

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Explosion of tank truck

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☒ Not while at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
10:20 a. m. p. m.	6/24/ 1960		Garage	Cumberland, Allegany Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: June 24, 1960

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	6/26/1960	Sunset Burial Park	Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Charles L. George	Cumberland, Md.	JUN 27 '60	Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6483 — 06440 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b: 31yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Church Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: LAWRENCE — Middle: J — Last: ROONEY

4. DATE OF DEATH: Month: 6/4/1960 — Day — Year: 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8/15/1928

9. AGE (In years last birthday): 31 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not Employed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg, MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lawrence Rooney

14. MOTHER'S MAIDEN NAME: Margaret Flynn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-24-1965

17. INFORMANT — Address: Miss Mary Rooney, Lonaconing, Md. (SISTER)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY THROMBOSIS, LEFT — INTERVAL BETWEEN ONSET AND DEATH: 15-20 Min.

DUE TO (b): Coronary Sclerosis — ***

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D. — JUNE 4, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **22b. DATE THEREOF**: 6/7/60 — **22c. NAME OF CEMETERY OR CREMATORY**: St Marys Cemetery — **22d. LOCATION** (City, town, or county) (State): Lonaconing, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: George Eichhorn — Lonaconing, Md.

24a. REC'D BY REGISTRAR DATE: JUN 8 '60 — **24b. REGISTRAR'S SIGNATURE**: Carlton L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6485 6644i

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 70YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 186 W. MAIN STREET

2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 186 W. MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSARIA — Middle (MARRO) — Last RUFFO
4. DATE OF DEATH: Month JUNE — Day 24, — Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: AUG. 27, 1873
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): CELICO, ITALY
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANK MARRO
14. MOTHER'S MAIDEN NAME: ROSE TELLERICO

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: FRANK RUFFO, — Address: FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac arrest, heart failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) generalized high degree of arteriosclerosis
DUE TO
(c) incl. cerebral vessels age

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): large decubital ulcer, ascending kidney-pelvis infection
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from December, 1959, to June, 1960, that (I) (we) last saw the deceased alive on 6-22-60 19__, and that death occurred at 2: AM from the causes and on the date stated above.

22a SIGNATURE: Otto Vogel MD — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b DATE SIGNED
22c PHYSICIAN'S NAME (Type): OTTO VOGEL, M. D.
22d. ADDRESS: MAIN ST., FROSTBURG, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6-27-60
23c NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY
23d LOCATION (City, town, or county) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: FROSTBURG, MD.
25a REC'D BY REGISTRAR DATE JUN 28 '60
25b REGISTRAR'S SIGNATURE: Clifford L. Strauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06442

6463

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
1SM 9/59

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 11 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ECKHART
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: MARY — Middle: A. — Last: SCHURG

4. DATE OF DEATH: Month: JUNE — Day: 28 — Year: 19 60

5 SEX: FEMALE

6 COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPTEMBER 11, 1913

9. AGE (In years last birthday): 46 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: THOMAS WILLISON

14. MOTHER'S MAIDEN NAME: LILLIE TWIGG

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None

16 SOCIAL SECURITY NO: 220-07-6917

17 INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cystitis — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO (b): Carcinoma of Cervix — 3yrs +

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from June, 19 60 to June, 19 60 that (I) (we) last saw the deceased alive on June 27, 19 60 and that death occurred at 3:45 AM, from the causes and on the date stated above.

22a SIGNATURE: Doris Mould M.D

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. L. LEWIS MOULD

22d. ADDRESS: 122 SO. CENTRE ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6-30-60

23c NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

23d LOCATION (City, town, or county) (State): Eckhart, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Montesani — ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

25a. REC'D BY REGISTRAR: DATE JUL 11 '60

25b REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6464 06443

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4½ HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 430 GRAND AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First BERTHA — Middle MABEL — Last SHELLEY

4. DATE OF DEATH: Month JUNE — Day 8 — Year 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 17, 1891

9 AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): VIRGINIA, Berryville

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: DAVIS RIGGLEMAN

14. MOTHER'S MAIDEN NAME: PHEOBE C. EVERSOLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): no

16 SOCIAL SECURITY NO: none

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Ingestive Gastritis — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): acute myocardial Infarction — 2 months

DUE TO (c): arteriosclerotic and Hypertensive Cardiovascular Disease — 7 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 7 '60 to June 8 '60, that (I) (we) last saw the deceased alive on June 7 '60, and that death occurred at 3:30 A.M. from the causes and on the date stated above

22a. SIGNATURE: H. Alfred Van Ormer M.D

22b. DATE SIGNED

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22c. PHYSICIAN'S NAME (Type): DR. W.A. VAN ORMER

22d. ADDRESS: 112 Central St Cumberland, Md.

23a BURIAL CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: 6/12/60

23c NAME OF CEMETERY OR CREMATORY: Rock Oak Cemetery

23d LOCATION (City, town, or county) (State): Rock Oak, West Virginia

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

25a REC'D BY REGISTRAR DATE: JUN 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be forwarded to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 11/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6465

CERTIFICATE OF DEATH

06445

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CUMBERLAND Rt. # 3
d. STREET ADDRESS: Bedford Road.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First DENNIS — Middle LEE — Last SIMONS
4. DATE OF DEATH: Month JUNE — Day 9 — Year 19 60
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 3-31-60
9. AGE (In years last birthday): 0 yrs. — IF UNDER 1 YEAR: Months 2 Days 9 — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: RICHARD D. SIMONS
14. MOTHER'S MAIDEN NAME: RRANCES CHRISTMAN
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No,
16. SOCIAL SECURITY NO: None
17. INFORMANT — Address: Mr. Richard D. Simons, Rt. # 3 Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): intestinal obstruction Meckel's diverticulum
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): strangulated hernia Hydrocele
DUE TO (c): Operated on on 6/7/60
INTERVAL BETWEEN ONSET AND DEATH: 12 hours — a few hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): congenital anomaly of heart, cardiomegaly, anemia
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): 0
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (This hospital) attended the deceased from 6/6 19 60 to 6-9 19 60 that (I) (we) last saw the deceased alive on ____ 19 ____ and that death occurred at 1:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 6/10/60
22c. PHYSICIAN'S NAME (Type): DR. E. BRINGS
22d. ADDRESS: 55 Greene St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/11/60
23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Cem.
23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: H. Wayne George Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1 2 60 2 7 3 X

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6466 06445

1 PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE PENNSYLVANIA b. COUNTY BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEDFORD, (RURAL)
d. STREET ADDRESS ROUTE 3,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First ANNA Middle V. Last SIMPSON

4. DATE OF DEATH Month JUNE Day 27 Year 1960

5 SEX FEMALE 6 COLOR OR RACE WHITE 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH FEBRUARY 23, 1912 9 AGE (In years last birthday) 48 yrs

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11 BIRTHPLACE (State or foreign country) MAYSVILLE, W. VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [redacted] OCE MONGOLD
14. MOTHER'S MAIDEN NAME EMMA TURNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Chronic Rheumatic Heart Disease DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH Since 1954

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-25, 19 59 to 6-27, 19 60 that (I) (~~we~~) last saw the deceased alive on 6-27-60 and that death occurred at 12:20 AM, from the causes and on the date stated above

22a SIGNATURE W. F. Williams M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED 6-27-60
22c PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS
22d ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.

23a BURIAL CREMATION REMOVAL (Specify) Burial
23b DATE THEREOF June 29, 1960
23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
23d LOCATION (City, town or county) (State) Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarpelli, Cumberland, Md.
25a REC'D BY REG STRAR DATE JUN 30 '60
25b REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6467 — Reg. Dist. No. 6646

1 PLACE OF DEATH
a. COUNTY: Allegany

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 109 Park St.,

d STREET ADDRESS: 109 Park St.,

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Joseph Middle Critchfield Last Skinner

4. DATE OF DEATH: Month June Day 14, Year 19 60

5. SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 10, 1885

9 AGE (In years last birthday): 74 yrs

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Conductor

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy.

11. BIRTHPLACE (State or foreign country): Ohiopyle, Penna.

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Abraham Skinner

14. MOTHER'S MAIDEN NAME: Catherine Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No,

16. SOCIAL SECURITY NO: 705-09-6122

17 INFORMANT: Address: Mr. Randall Skinner, Connellsville, Pa.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4 - 28, 19 60, to 6 - 14, 19 60, that I last saw the deceased alive on 6 - 14, 19 60, and that death occurred at 5:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph W. Ballin M.D. ADDRESS (Street, city or town, state): 62 Greene St., DATE SIGNED: 6 - 16-60

PHYSICIAN'S NAME (Type): Ralph W. Ballin M. D. Cumberland, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/17/60

22c NAME OF CEMETERY OR CREMATORY: Hickman Baptist Cem.

22d. LOCATION (City, town, or county) (State): Mill Run, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: H. Wayne George Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: JUN 20 '60

24b REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6499

CERTIFICATE OF DEATH

06447
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 50yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rt#2 Williams Road

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cumberland
d. STREET ADDRESS: Rt#2 Williams Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Alonzo; Middle: E.; Last: Snider

4. DATE OF DEATH: Month: June; Day: 21; Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 6, 1869

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self emp.

11. BIRTHPLACE (State or foreign country): Kingwood, W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Amos Snider

14. MOTHER'S MAIDEN NAME: Susanna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b): Arteriosclerotic Cardiovascular Disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 19 54 to June 19 60 that I last saw the deceased alive on June 21 19 60, and that death occurred at 1:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED: 6/21/60

PHYSICIAN'S NAME (Type): G. Overton Himmelwright — 133 Virginia Ave. Cumberland, Md.

22a. BURIAL CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-23-60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cem.
22d. LOCATION (City town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: JUN 22 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6468 06448

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL, MEMORIAL AVENUE

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALEEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 33 VIRGINIA AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
HILDA	C.	SPEARMAN	JUNE	14	1960

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
FEMALE	WHITE		NOVEMBER 3, 1900	59 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Worp Knitting	Textile	Cumberland, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ANDREW SPEARMAN	ROSE F. NEUSCH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT Address
No		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertensive Uremia

DUE TO (b) Hypertensive Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 2 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a m p m Month, Day, Year 19	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Apr 28th, 19___, to Apr 13th, 19___, that (I) (we) last saw the deceased alive on Apr 13th 19___, and that death occurred at 4:50 AM, from the causes and on the date stated above.

22a SIGNATURE: [signature] M.D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 6/15/60

22c PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS

22d ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	6-17-60	St. Peter & Paul Cem.	Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James F. Scarpelli Cumberland, Md.	JUN 20 '60	Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6469 0644

1 PLACE OF DEATH
a COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c LENGTH OF STAY IN 1b: 5 hours
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a STATE: MARYLAND
b COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BOX 11 ELLERSIE
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JAMES Middle JOSEPH Last SPEARMAN

4. DATE OF DEATH: Month JUNE Day 26 Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 23 1894
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Car Insp.
10b. KIND OF BUSINESS OR INDUSTRY: B & O Railroad
11 BIRTHPLACE (State or foreign country): PA. Pittsburgh
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH J. SPEARMAN
14. MOTHER'S MAIDEN NAME: Alice MARY CLARK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO: 705-09-6682
17. INFORMANT: PTS.CHART. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO
(b): Arteriosclerotic heart disease — 4 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour o. m. p. m Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 2-3 1960, to 6-26 1960, that (I) (we) last saw the deceased alive on 6-26 1960, and that death occurred at 4: P.M. from the causes and on the date stated above.

22a. SIGNATURE: L Brings M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 6/27/60
22c. PHYSICIAN'S NAME (Type): Louis Brings, M.D.
22d. ADDRESS: 576 Greene St. Cumberland Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6/29/60
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Catholic Cem.
23d LOCATION (City, town, or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland
25a RECD BY REGISTRAR DATE: JUN 30 '60
25b REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death [illegible] may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6470 Reg. Dist. No. 0150

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 61 Cresap Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: David Middle: R. Last: Stallings

4. DATE OF DEATH: Month: June Day: 29 Year: 1960

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 6, 1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Concrete Mason
10b. KIND OF BUSINESS OR INDUSTRY: Masonary
11. BIRTHPLACE (State or foreign country): Cumberland, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathan Stallings
14. MOTHER'S MAIDEN NAME: Anna C. Twigg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. R.F. VanHorn Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Congestive Heart Failure	5 Wks
DUE TO (b)	Coronary Artery Disease	??
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Generalized Arteriosclerosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-24 19 60 to 6-29 19 60, that I last saw the deceased alive on 6-29 19 60, and that death occurred at 7:05 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William P Tumas M.D. ADDRESS (Street, city or town, state): 414 N Centre St DATE SIGNED: 7-1-60

PHYSICIAN'S NAME (Type): William P. Tumas Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 1, '60	Mt. Herman Cem.	Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fawn Thomas and Son ADDRESS: Cumberland, Md
24a. REC'D BY REGISTRAR DATE: JUL 7 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6486 06451

1 PLACE OF DEATH
a COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 45 Yrs.
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miner's Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: MARYLAND
b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d STREET ADDRESS: 148 Maple Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: — Last: Stark

4. DATE OF DEATH: Month: June — Day: 2nd, — Year: 19 60

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: June 25th, 1884
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John M. Stark
14. MOTHER'S MAIDEN NAME: Jean Robertson

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 213-09-6544
17 INFORMANT: Mrs. Virginia Stark, Address 148 Maple St., Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial Insufficiency
DUE TO (b): Cardiac
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

241X

INTERVAL BETWEEN ONSET AND DEATH: 5 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from May 17, 19 60 to June 2, 1960, that (I) (we) last saw the deceased alive on June 2, 1960, and that death occurred at 4:10 P.M. from the causes and on the date stated above.

22a SIGNATURE: W. O. McLane, M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: June 4 '60
22c PHYSICIAN'S NAME (Type): W. O. McLane, "
22d. ADDRESS: Frostburg, Md.

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6-4-60
23c NAME OF CEMETERY OR CREMATORY: Porter Cemetery
23d LOCATION (City, town or county) (State): Eckhart, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Frostburg, Md.
25a REC'D BY REGISTRAR DATE: JUN 8 '60
25b REGISTRAR'S SIGNATURE: Arthur S. Braun

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6487

CERTIFICATE OF DEATH

06452

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D # 1 Frostburg

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: — Last: Steele

4. DATE OF DEATH: Month: June — Day: 22 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 26, 1888

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Klondyke, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred Cutter

14. MOTHER'S MAIDEN NAME: Ellen Humberson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: James Steele "Husband" — Address: Gilmore, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO (b): Coronary & Generalized sclerosis with — 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): chronic heart insufficiency age

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): had severe Virusinfection with bronchopneumonia 2 months ago

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): no

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-21-60, 19 to 6-22-60, 19, that (I) (we) last saw the deceased alive on 6-20-1960, and that death occurred at 5:20 P. M. from the causes and on the date stated above

22a. SIGNATURE: Otto Vogel M.D — M.D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6-23-6

22c. PHYSICIAN'S NAME (Type): Otto Vogel, M.D.

22d. ADDRESS: 167 East Main, Frostburg, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/25/60

23c. NAME OF CEMETERY OR CREMATORY: Steele Cemetery

23d. LOCATION (City, town, or county) (State): Near Lonaconing, Md

24. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn

ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: JUN 27 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6471

CERTIFICATE OF DEATH

0645.3
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: years

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 440 North Mechanic Street

d. STREET ADDRESS: 440 N. Mechanic Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle HANNAH Last STEELE

4. DATE OF DEATH: Month June Day 4 Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 30, 1882
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Braddock Farms, Alleg. Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Steele
14. MOTHER'S MAIDEN NAME: Minnie Louise Kerr

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
If yes, give war or dates of service:
16. SOCIAL SECURITY NO: none

INFORMANT: Mrs. James Kerr
Address: 119 Valley Street Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CHRONIC CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 1 MO
DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE
DUE TO (c):

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): OSTEOPOROSIS, DEGENERATVIE ARTHRITIS

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 21 APRIL, 1960, to 4 JUNE, 1960 that I last saw the deceased alive on 1 JUNE, 1960, and that death occurred at 5:00AM from the causes and on the date stated above.

ACTUAL SIGNATURE: William P James M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 6-6-60

PHYSICIAN'S NAME (Type): William P. James M.D. 441 N. Centre St. Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/6/60
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cmetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE JUN 7 '60
24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6472

CERTIFICATE OF DEATH

0645

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MARYLAND
d. STREET ADDRESS: 106 WEST SECOND ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GREGORY — Middle MILTON — Last STEWART

4. DATE OF DEATH: Month JUNE — Day 24 — Year 19 60

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 14, 1960

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months — Days 10 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MILTON J. STEWART

14. MOTHER'S MAIDEN NAME: LA VERNE M. EVANS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Patent Ductus Arteriosus — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Patent Foramen Ovale

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c): Hemmorhage Kidneys

754.1

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congenital Stenosis Descending Colon. — 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____ 19___, to _____ 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at 8:20 P.M. The causes and on the date stated above.

22a. SIGNATURE: Dallas B Whitworth M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 27 Jun 60

22c. PHYSICIAN'S NAME (Type): DR. F.B. WHITWORTH

22d. ADDRESS: 123 BEDFORD ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-27-60

23c. NAME OF CEMETERY OR CREMATORY: St. Patrick Cem

23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli Cumberland, Md.

25a. RECD BY REGISTRAR DATE: JUN 28 60

25b. REGISTRAR'S SIGNATURE: Clifton L. Mann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2060 24 2 X V

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6473 — 06455

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 1209 Union Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK — Middle J — Last WAGNER
4. DATE OF DEATH: Month June — Day 5 — Year 1960
5. SEX: MALE
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/5/97
9. AGE (In years last birthday): 63 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Celanese
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George Wagner
14. MOTHER'S MAIDEN NAME: Estella Martz
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): War I
16. SOCIAL SECURITY NO.: 217-10-4240
17. INFORMANT: Mrs. Frank Wagner, Cumberland, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): or Generalized Arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 420.1

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from June 5 1960 to June 5 1960 that (I) (we) last saw the deceased alive on June 4 1960, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: B. Schindler MD, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. B. Schindler.
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 8, 1960
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City, town or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR — DATE: JUN 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6474

CERTIFICATE OF DEATH

0645[illegible]

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 dys.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 632 N CENTER STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle CARL Last WEISENMILLER

4. DATE OF DEATH: Month JUNE Day 1 Year 19 60

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/13/97 ~~1-21-1897~~ 1/13/97

9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Cumb. Brewery

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN WEISENMILLER

14. MOTHER'S MAIDEN NAME: ANNA SCHMIDT

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes, (If yes, give war or dates of service): W.W.# 1

16. SOCIAL SECURITY NO: 214-05-4841

17. INFORMANT: Mrs. Pearl Weisenmiller Address: 632 N. Centre St. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Arteriosclerotic heart disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a m p m Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-4- 19[illegible] to 6-1- 19[illegible] that (I) (we) last saw the deceased alive on 1/ 19[illegible] and that death occurred at [illegible] M, from the causes and on the date stated above

22a. SIGNATURE: L. Brings M.D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6/2/60

22c. PHYSICIAN'S NAME (Type): DR. L.BRINGS

22d. ADDRESS: 57 GREENE STREET Cumb. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/4/60

23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul's

23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: H. Wayne George Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: JUN 6 '60

25b. REGISTRAR'S SIGNATURE: Clothier L. Hance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death [illegible] may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M ■/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06457

6475

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 2yrs.1mo.13da.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat

d. STREET ADDRESS: 173 N. Mechanic St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Rose — Last: Weston

4. DATE OF DEATH: Month: June — Day: 7 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/10/80

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William H. Rose

14. MOTHER'S MAIDEN NAME: Elizabeth Brust

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None.

17. INFORMANT: Sylvan Retreat — Address: Cumb. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 422 Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): 451 General Arteriosclerosis — ?

DUE TO (c): 304 Senile psychosis — 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 171 Malignant neoplasm cervix Uteri

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr. 25th 1958 to June 7th 1960, that I last saw the deceased alive on June 6th 1960, and that death occurred at 10 50 P M, from the causes and on the date stated above

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. Cumberland Md — DATE SIGNED: 6/8/60

PHYSICIAN'S NAME (Type): James E. McLean, M.D. — 49 Greene St., Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 6/15/60 — 22c. NAME OF CEMETERY OR CREMATORY: County Cem. — 22d. LOCATION (City, town or county): Cumberland (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. — ADDRESS: Cumb. Md

24a. REC'D BY REGISTRAR DATE: JUN 17 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 File No. 5-2)-61 e

6476

CERTIFICATE OF DEATH

0645

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sacred Heart Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): C.2. Cumberland,
d. STREET ADDRESS: 314 Fayette St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hannah — Middle: Jane — Last: Willetts

4. DATE OF DEATH: Month: June — Day: 15, — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 31, 1880

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Franklin, Md.

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13 FATHER'S NAME: George Whitefield

14. MOTHER'S MAIDEN NAME: Catherine (Unknown)

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No, (If yes give war or dates of service):

16 SOCIAL SECURITY NO:

17. INFORMANT — Address: Mr. John Willetts 314 Fayette St., Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Gangrene, Intestinal — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Mesenteric Thrombosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Umbilical Hernia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I attended the deceased from 6/14, 1960, to 6/15, 1960, that I last saw the deceased alive on 6/14/60, 1960, and that death occurred at 1:45A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo H. Ley Jr. M.D.

ADDRESS (Street, city or town, state): 456 N. Centre St., Cumberland, Md.

DATE SIGNED: 6/15/60

PHYSICIAN'S NAME (Type): Leo H. Ley Jr. M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/17/60

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d LOCATION (City, town, or county) (State): Cumberland, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George

ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: JUN 20 '60

24b REGISTRAR'S SIGNATURE: Clarence S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6477 Reg. Dist. No. 6459

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 45 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 318 Arch St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 318 Arch St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Thomas — Middle: — Last: Williams, Sr.

4. DATE OF DEATH: Month: June — Day: 18 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 8, 1884

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boilermaker

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David A. Williams

14. MOTHER'S MAIDEN NAME: ~~XXXXX~~ Eliza Dix

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ~~XXXXXXXXXXX~~

16. SOCIAL SECURITY NO.: 705-05-4509

17. INFORMANT: Mrs. John T. Williams, Address: Cumberland Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary Sclerosis — ---

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: June 19, 1960

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-21-1960
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: JUN 21 '60

24b. REGISTRAR'S SIGNATURE: Catherine L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06460

6500

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt #2 Flintstone
c. LENGTH OF STAY IN 1b: 11 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rt #2 Flintstone
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Claude — Middle: R — Last: Wilson

4. DATE OF DEATH: Month: June — Day: 2 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 15, 1880

9. AGE (In years last birthday): 79 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas J. Wilson

14. MOTHER'S MAIDEN NAME: Elizabeth Robinette

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 220-30-8654

17. INFORMANT: Ralph Wilson — Address: Cumberland Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a m / p m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 15 1960 to June 2, 1960, that (I) (we) last saw the deceased alive on June 2 1960, and that death occurred at 11 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Benedict Skitarelic M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Benedict Skitarelic, M.D.

22d. ADDRESS: R.D. # 9 Cumberland Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/4/60

23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery

23d. LOCATION (City, town, or county) (State): Flintstone Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ruth E. Silcox Cumberland Maryland

25a. REC'D BY REGISTRAR DATE: JUN 6 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6501 0646i

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Near Cumberland
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box #157 Oldtown Road

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ural,near Cumberland
d. STREET ADDRESS: Box #157 Oldtown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First SAMUEL Middle — Last WILSON

4. DATE OF DEATH: Month June Day 12 Year 19 60

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Feburary 14, 1881

9 AGE (In years last birthday): 79 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ret.ired

10b. KIND OF BUSINESS OR INDUSTRY: Kelly-Springfield

11. BIRTHPLACE (State or foreign country): Warriors Mt. Allegany Co.Md. USA

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: OLIVER WILSON

14 MOTHER'S MAIDEN NAME: EMILA TUIGG

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO: 215-20-6738

17 INFORMANT: Baltimore Pike — Mrs. John Raines, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — DUE TO (b): Fibrosis of Pneumonia two years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Some

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Sept-X, 19 59 to June 12, 19 59 that (I) (we) last saw the deceased alive on June 12 19 60 and that death occurred at ____M, from the causes and on the date stated above.

22a SIGNATURE: Clay E. Durrett M.D.

ATTENDING PHYS X MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type): Clay E. Durrett M.D.

22d ADDRESS: 236 Va. Ave., Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: June 15, 1960

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Lafer, Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 16 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 11/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6478 **CERTIFICATE OF DEATH** Reg. Dist. No. 06462

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 412 Cumberland, St.,

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 412 Cumberland St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First CLARENCE — Middle WILLIAM — Last WOLFORD

4. DATE OF DEATH: Month June — Day 15, — Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 20, 1886

9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Store Prop.

10b. KIND OF BUSINESS OR INDUSTRY: Groceries

11. BIRTHPLACE (State or foreign country): Allegany Co. Md.

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Frank Wolford

14. MOTHER'S MAIDEN NAME: Mary Schlunt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 215-20-5140

17. INFORMANT: Miss Mary C. Wolford — Address: 412 Cumb. St. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:
4-50.0
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 19 55, to 6/15, 19 60, that I last saw the deceased alive on 6/14, 19 60, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo N. Ley, Jr. M.D. — ADDRESS (Street, city or town, state): 456 N. Centre St., — DATE SIGNED: 6/15/60

PHYSICIAN'S NAME (Type): Leo H. Ley Jr. M. D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/17/60
22c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cem.
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: JUN 20 60

24b. REGISTRAR'S SIGNATURE: Arthur J. Norris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6479 — Reg. Dist. No. 06463

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 210 Valley Street.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland Md.
d. STREET ADDRESS: 210 Valley Street.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUSIE — Middle ANNA — Last WOLZ
4. DATE OF DEATH: Month June — Day 4 — Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 23, 1890
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Artemas Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Asberry Perdew
14. MOTHER'S MAIDEN NAME: Emily Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Mr. Charles E. Wolz. 210 Valley St. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CORONARY SCLEROSIS — —
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: June 4, 1960
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 7, 1960
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Louis Stein Inc. 117 Frederick Street.
24a. REC'D BY REGISTRAR DATE: JUN 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6480 **CERTIFICATE OF DEATH** Reg. Dist. No. 06464

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Lifetime

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: Irons Mountain
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Irons Mountain

3. NAME OF DECEASED (Type or print): First Nettie Middle Hannah Last Zimerly

4. DATE OF DEATH: Month June Day 8 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 21, 1880
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Conrad Shatzer
14. MOTHER'S MAIDEN NAME: Sidney Daniels

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Hervey F. Zimerly Address: Irons Mountain

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 199.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/1/2 19[illegible] to 6/1/5 19[illegible], that I last saw the deceased alive on 5/16/60 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George M Simons M.D. ADDRESS (Street, city or town, state): Algonquin Hotel, Cumberland, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. George M. Simons, MD June 10, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 10, 1960
22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE JUN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57